people transition socially without contact with a GIC, and others self-medicate with hormone therapy bought online.

Psychiatry and psychiatrists often have a poor reputation among sexual minority groups, for very understandable historical reasons. To overcome this, we need to provide genuinely inclusive care – which starts with knowledge and understanding.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87,

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Authors' reply: We thank Margaret White for responding to our editorial[1] and would like to take this opportunity to respond to some of the points she makes. First, she argues that we conflated gender identity and sexual orientation and treated LGBT youth as a 'monolithic entity'. We agree that LGBT young people are not a 'monolithic entity'. We stated clearly that we think it is important to understand the experiences of LGBT young people and to identify where risks for engaging in suicidal behaviour differ between groups. We also gave brief illustrative examples of why risk factors may vary between groups.

On the basis of the findings of the Miranda-Mendizábal review[2] we stated there was insufficient data to draw firm conclusions on differences in risk of suicidal behaviour among LGB young people. In addition, the Miranda-Mendizábal review did not assess risk factors in transgender young people and therefore we could not draw conclusions from that study on differences in risk factors experienced by transgender young people and other populations. However, it is important to clarify that this does not imply that we think LGBT young people constitute a monolithic entity or that we are conflating sexual orientation with gender identity.

Second, White provides two examples that she considers reflects a conflation of gender identity and sexual orientation. We are sorry for any misunderstanding and acknowledge that wording could have been more precise.

Reading the first paragraph of the background section in context, we thought it was clear that we were not suggesting transgender young people cannot be heterosexual. Reading the two sentences that immediately follow the first sentence cited by White makes clear that the comparative data we refer to are between LGB and heterosexual young people. The data on suicidality in LGBT groups that we cited is non-comparative data.

White is correct there are two toolkits developed by Public Health England and the Royal College of Nursing that are presented together on the same web page as guidance on 'Preventing suicide: lesbian, gay, bisexual and trans young people' (www.gov.uk/government/publications/preventing-suicide-lesbian-gay-and-bisexual-young-people). We're sorry for any misunderstanding caused by the article inadvertently using the singular 'a toolkit'.

Third, as regards risk factors for transgender youth, we agree that there are a number of potential factors that may have an impact on risk of suicidality in transgender young people. When read in context as a suggestion for further research on risk factors for suicidal behaviour in transgender populations, we thought it was clear that we were citing higher rates of stigma as an illustrative example and not intending to provide a comprehensive list of risk or protective factors, as that would be pre-empting what emerges from future research.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87.

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Authors' reply: We thank Meader & Chan[1] for their appreciation that our review updated and refined the evidence on risk of suicidal behaviour in LGB youth. We concur with these authors that there is a lack of research about suicidal behaviour among the LGBT population. Moreover, we firmly believe that there is a need for identifying specific risk and protective factors of suicidal behaviour in this population, especially among transgender people, for better prevention. Although some factors may be common for the whole LGBT population, it is likely that different mechanisms may be operating. Longitudinal assessment of mediators such as victimisation, stigmatisation and discrimination might help to identify causal pathways for suicidal behaviours, specifically regarding sexual orientation and gender identity.[2]

We agree with White that it is important to distinguish between gender identity and sexual orientation. Considering LGBT as a monolithic identity may not be adequate since sexual orientation is a multidimensional concept referring to an enduring pattern of emotional, romantic and/or sexual attraction to males, females or both genders,[3] whereas gender identity is one's own sense or conviction of maleness or femaleness.[4] Therefore, homosexuality or heterosexuality must be understood only as forms of sexual expression, whereas transgenderism corresponds to gender identification. Sexual orientation and gender identity ought to be measured in a homogeneous way, preferably using the same definition by expert consensus, to allow comparisons between studies.[2]

Owing to the relatively small number of observations, many research studies assessing health problems among minorities are forced to consider different population groups as a single category. The LGBT population is a clear example of this is. As a previous study showed, individuals see the importance of giving health providers information about their gender identity rather than just their sexual orientation.[5] Given the underrepresentation of transgender patients in healthcare and the general population, it is crucial to include LGBT education for healthcare providers, and to provide a safe environment for LGBT individuals. These results can be a starting point for a more specific assessment of the health disparities among the LGBT population, considering that factors may affect these individuals in diverse ways.

1 Meader N, Chan MKY. Sexual orientation and suicidal behaviour in young people. *Br J Psychiatry* 2017; **211**: 63–4.

2 Miranda-Mendizábal A, Castellví P, Parés-Badell O, Almenara J, Alonso I, Blasco MJ, et al. Sexual orientation and suicidal behaviour in adolescents and young adults: systematic review and meta-analysis. *Br J Psychiatry* 2017; **211**: 77–87.

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The medical profession and stigma against people who use drugs

Corrigan *et al*[1] argue that stigma against people who use drugs is 'in some ways socially, politically, and/or legally sanctioned' and discuss this with reference to the criminal justice system, the workplace and health promotion strategies. How the medical profession, medical diagnosis, medical language and medical models of addiction might be propagating stigma is not discussed and we offer some examples.

First, terms widely used by the medical profession to describe people who use drugs are apparently neutral and objective, but in fact convey negative attributes. For instance, 'drug abuse' can be taken to imply that people who use drugs do so to deliberately inflict harm upon themselves. The use of this term also implies that there is a universally recognised standard for the 'proper use' of a given substance, when there is not.

Second, medical diagnosis is normative. The ICD-10 and DSM-5 define addiction by identifying normative standards of behaviour that people with drug dependency fail to achieve. For instance, one DSM criterion identifies drug use 'resulting in failure to fulfil major role obligations at work, school, or home'. As Matthews *et al*[2] put it: 'to be diagnosed with addiction under these systems [. . .] is to be classified as morally compromised or deficient'.

Third, medical models of understanding cast people who use and/or are dependent on drugs in a negative light. The cause of dependent drug use is contentious. Is it the result of moral choice, a disease, or normal brain changes that result from habit acquisition? The 'moral model' of drug use holds drug use as a choice, and has a critical stance against this choice, legitimising stigma. The 'disease model' sees dependent drug use as a result of neurobiology. This model underpins the medical approach to dependent drug use, where a diagnosis, based on symptoms and history, leads to prescribed treatment. Although this approach absolves responsibility, and therefore the potential for stigma via blame, it nevertheless influences stigma by casting dependent drug users as helpless victims.[3]

Fourth, healthcare professionals are unsympathetic to people who use drugs. There is evidence that negative attitudes of healthcare professionals towards patients who use drugs are widespread.[4] This may affect drug users' self-stigma. Gilchrist *et al*[5] found that healthcare professionals appear to attach lower standing to working with people who use drugs than to work other patient groups. Since healthcare professionals are influential, these negative attitudes may engender stigma elsewhere.

Fifth, there is the matter of doctors and drug policy reform. As Corrigan *et al* point out, criminalisation fuels stigmatisation. Criminalisation is also responsible for many of the harms associated with drug use, for instance violence associated with the black market in drugs, and adulterated supply. Doctors are in a position to influence drug policy away from blanket criminalisation towards a more nuanced approach which more closely correlates to the potential for harm. Some organisations representing doctors have called for changes but 'such calls are far from universal – and far from loud enough'.[6]

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Authors' reply: In response to our editorial in the *BJPsych*,[1] Ginn & Clark note that medical professionals add to the stigma of substance use disorders. Sadly, their insights parallel the larger research on the stigma of mental illness and psychiatry: namely, psychiatric service providers tend to be among the most stigmatising of professions. This can be surprising because most providers would seem to pursue advanced degrees for reasons of altruism: to help people with behavioural health challenges. Research suggests, however, that patients and their families often describe mental health professionals as the source of stigma, with specific providers frequently focusing on the disease and ignoring the person.[3] As many as half of providers fail to endorse recovery as an outcome for serious mental illness. Psychiatrists, in particular, are often found to be more pessimistic about mental illness compared with other provider groups. Mental healthcare providers endorse stereotypes about mental illness, including perceptions of dangerousness, unpredictability and blame. Stigma undermines the provision of care.[3] Studies have shown that up to half of participating psychiatrists did not share a diagnosis of schizophrenia with the patient unless specifically asked or failed to engage patients in such real-life matters as finance, accommodation and leisure.

Unfortunately, the stigma shown by mental healthcare providers extends to healthcare providers in general, perhaps in even more sobering ways. Studies comparing patients with and without identified mental illness have shown that healthcare providers are less likely to refer patients with mental illness for mammography, hospital admission after diabetic crisis, or cardiac catheterisation.[2] To make sense of the direct relationship between stigma and healthcare decisions, one study examined views of primary care and psychiatric physicians and nurses towards people with mental illness.[4] Results showed that providers who endorsed stigmatising ideas about a patient with mental illness presenting for arthritic pain were less likely to refer the person for a consultation and less likely to refill their analgesic prescription. This relationship was

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